Welcome To Our Office

PATIENT INFORMATION

Name (Last, First, Middle) ____Nickname_______________________

Address____ City _____________________ State ______ Zip___________

Cell Phone________________________ Home Phone________________________ Work Phone_______________________

Birth Date ___________________________ Age________ Email ____

❑M ❑F ❑Other ❑Single ❑Married ❑Other SS#____

Primary Care Physician ____________________________ Race / Ethnicity _____________________________________

Clinic Name ____________________________________ Preferred Language ❑English ❑Other ________________

Occupation: ____________________________________ Hobbies: ____

It is ok to discuss my account and health information with the following person:_____________________________________

It is ok to leave ***detailed messages*** about my account and health information on my (*check all that apply*):

❑ Voice Mail ❑ Text ❑ Email

Who may we thank for your referral? ____

PERSON RESPONSIBLE FOR BILLING (if same as above, check ❑)

Name (Last, First, Middle) ____

Mailing Address____________________________________ City _____________________ State ______ Zip___________

Home Phone_______________________ Work Phone________________________ Cell Phone_______________________

Other ____ Email ____

Birth Date ___________________________ Age________ SS#____

INSURANCE INFORMATION

Vision Insurance __________________________________ ID# __________________________Group#______________

Name of Insured ____ Birth Date __________ Last 4 SSN _______

Medical Insurance ________________________________ ID# __________________________Group#______________

Name of Insured ____ Birth Date __________ Last 4 SSN _______

Please read the following and sign below:

- MISSED APPOINTMENT FEE: If I miss or cancel an appointment within 24 hours, I will pay a $50 fee.
- We will bill INSURANCE as a courtesy to you. If your insurance pays less than expected the balance is your responsibility.
- If COLLECTION actions become necessary, I will pay all costs of collection and attorney fees in addition to the amount owed.
- PRIVACY PRACTICES: I have read and understand the Evergreen Eye Care privacy policy (HIPAA Notice).
- ASSIGNMENT and RELEASE: I request that payment from my insurance company, if applicable, be made on my behalf to my providing doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature (of Responsible Party) ________________________________ **Date**________________

DO YOU… 💧 Currently wear contact lenses?

💧 Want to try contact lenses?

- When you wear contacts, our doctors do an evaluation to ensure the proper lens fit.
- Most insurance companies DO NOT cover the cost of a contact lens evaluation
- The evaluation ranges from $60 to $180, depending on the lens that is best for you.

❑ **YES!** I would like a contact lens evaluation and prescription! ______ (initial here)

❑ ***YES!*** *I will receive a written copy of my prescription once finalized ______ (initial here)*

HEALTH HISTORY

Please list any medications you take & the reason for taking them: ____

____

Are you allergic to any medications? ____

Do **you *currently*** have any problems in the following areas? If "yes", please explain:

	NO	YES
Eye Conditions (glaucoma, diabetic retinopathy, macular degeneration, other)	❑	❑ ______________________
General Constitution (fever, weight loss, other)	❑	❑ ______________________
Allergy/Immunologic (hay fever, lupus)	❑	❑ ______________________
Blood / Lymph (high cholesterol, anemia)	❑	❑ ______________________
Cardiovascular (blood vessel condition, heart disease)	❑	❑ ______________________
Ears, Nose, Throat (cold, sinus, cough)	❑	❑ ______________________
Endocrine (diabetes, thyroid)	❑	❑ ______________________
Gastrointestinal (ulcers, intestinal disease)	❑	❑ ______________________
Genital (kidney disease, bladder)	❑	❑ ______________________
Neurological (Multiple Sclerosis, seizures, stroke)	❑	❑ ______________________
Psychiatric (anxiety, depression)	❑	❑ ______________________
Respiratory (asthma, COPD, emphysema)	❑	❑ ______________________
Skin (rosacea, melanoma)	❑	❑ ______________________

Does anyone in your **family** have a history of: ❑ Diabetes ❑ Glaucoma ❑ Macular Degeneration

Do you use any of the following on a regular basis: ❑ Alcohol ❑ Tobacco ❑ Other Substances

Thank you for taking the time to fill out this form!